City of Huntsville

Injury Investigation Report

Injury Information

Date of Injury _____ Time _____

Name of Injured _____ SSN # _____ DOB _____

Sex ◯Male ◯Female Marital Status ◯S ◯M ◯W ◯D Spouse Name _____

Minor Children _____

Address _____ City _____ State _____ Zip _____

Phone # - Cell _____ Home _____ Work _____

Location of Accident _____

Explain what you were doing at time of Accident

Description of Accident, Injury, and part of body affected (Left, Right)

Was medical attention sought? Yes or No

Witness Information

Witness Name _____ Address _____ Phone # _____

Witness Name _____ Address _____ Phone # _____

Other Information

Safety equipment being used? ◯Yes ◯No

Corrective Actions - *include persons with assigned responsibilities and completion date for each.*

IF MEDICAL CARE IS NEEDED; MY SUPERVISOR DID ADVISE ME THAT I HAVE THE RIGHT TO CHOOSE THE PHYSICIAN OF MY CHOICE, BUT TO AVOID CONFLICT WITH MY CLAIM, I WILL SEE THE DESIGNATED WORKERS' COMP PHYSICIAN AT TIME OF INJURY.

Signature _____ Date _____

The information provided in this report is accurate to the best of my knowledge.

Employee Signature _____ Date _____

Supervisor Signature _____ Date _____

To be completed by Safety Officer

Date of Employment _____ Department _____ Position _____

Last Paycheck Amount _____ Total Hours _____ Classification Code Reported _____